Case Management Bridge Crossings

Bridging the Chasms of Case Management . . . making it a reality

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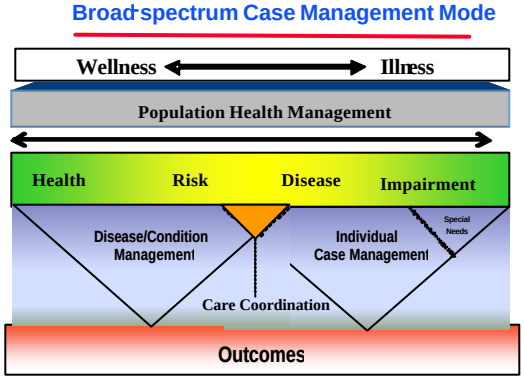
*Last issue highlighted **LOD, MEB, and PEB** as programs to consider in case management of the Active Duty Service Member(ADSM). This issue will feature the term **"care coordination"** and we will postpone discussion of integrated care management, catastrophic case management, and population-based case management until next Bridge Crossings. **Care coordination** is evolving as an excellent short-term strategy to reduce costly clinical and financial outcomes.*

CARE COORDINATION: The Crucial Area of Overlap

***Care coordination**: a little more than discharge planning, but not enough for case management. Too diverse for disease management label, but distinctive enough to warrant a unique title. Care coordination is a discrete process that impacts clinical and fiscal outcomes. It is the "acute" part of the continuum between individual case management and disease management -- the "**overlapping area**".*



Webster defines coordination as "the harmonious functioning of parts for effective result; to act together in a smooth concerted way". The goal of care coordination is to provide smooth, harmonious transition of care and services across settings, and assist patients with navigating complex health care systems for access, and other services. Care coordination is an effective way to link patients to services, monitor patient response to treatment, and ensure timely follow-up. Care coordination occurs on-site or telephonically, usually of short term duration but often intense intervention. It may begin in the inpatient or outpatient setting, but essential activities occur at the "overlap" of individual case management and disease management.

When care coordination begins in the inpatient setting, the tasks involve more that those associated with discharge planning activities. Discharge planning ends when the patient leaves the hospital, but care coordination continues post-discharge into the home, outpatient, or other level of care. An example of care coordination originating in the inpatient setting is a patient [individual case management] requiring home intravenous therapy through a newly-inserted central venous catheter. A discharge planner may arrange for home health, medications, and supplies. Care coordination would extend to follow-up telephone calls to monitor patient response, continue education on treatment and site care, report progress to provider, and assess other factors affecting health such as pain, nutrition, hygiene, etc. Periodic monitoring affords opportunities to intervene on problems early and prevent readmission to the inpatient setting.

In the outpatient setting, care coordination targets patients who may be experiencing an exacerbation of a chronic disease [disease management] and undergoing treatment for an acute episode. Care coordination would connect patients to services, medication, and specific education to move them through the acute episode. The goal is preventable admission for acute symptoms of the patient's chronic disease. There are often multi-specialty care requirements, diagnostic studies, and extensive short term treatments that if not coordinated and monitored, would result in adverse health and cost outcomes.

Care coordination is an integral part of any medical management program, but is not always discretely defined. In March 2000, Mathematica Policy Research, Inc. conducted a study of coordinated care programs throughout the country (http://cms.hhs.gov/healthplans/research/FR-ESSTA.PDF). The study identified a common theme through case and disease management programs – care coordination tasks that included three steps: Asses and Plan, Implement and Deliver, Reassess and Adjust.

An effective care coordination program has specific tasks to achieve consistency and uniformity. This is especially important when a care coordination program is developed to target a specific population [condition management]. The Pediatric Clinic at Hill AFB, UT used the FOCUS-PDCA as the steps in a care coordination program that targets newborns delivered at local civilian hospitals. The Pediatric clinic wanted to "re-capture" newborns and make the clinic the "first choice" for care and to ensure continuity of care between settings. An excerpt of their newborn program follows (submitted by Nancy A. Keithley, Capt, USAF, NC.

F*ind a process to improve:* Recapture newborns in local hospitals and transition care to MTF Pediatric clinic.
O*rganize a team of experts:* New Parent Program Nurse, Health Care Integrator, TRICARE Contractor.
C*larify current knowledge:* Well-baby visit made immediately after delivery for civilian clinic. Few return to MTF.
U*nderstand process variations:* MTF access; Parent choice for civilian or MTF care; Provider/Parent bonds formed at time of delivery.
S*elect an improvement:* Clinic receives weekly newborn list. Staff calls parent to offer MTF appointment.
P*lan the improvement:* New Parent Program Coordinator obtains list from area hospitals. Babies registered in CHCS with first well baby appointment.
D*o:* Implement the plan, call parents, set up appointments, and follow-up in 3-6 months
C*heck and study results:* List not sent routinely – enlisted help from TRICARE Contractor who routinely interacts with civilian hospitals. Nurse makes initial call due to parental questions related to newborn care.
A*ct to hold improvement gain:* Trend the ratio of # of contacts to # of appointment made; educate staff; afford same opportunity if parent initiates contact; and reevaluate.

The success of MTF level programs is a result of regional commitment to the care coordination process. TRICARE Central and the Lead Agent Office were one of the first regions to formally establish care coordination through a Memorandum Of Understanding between the TRICARE contractor and the MTF. The BCMP model includes care coordination as a crucial part of the continuum of care and its impact should not be underestimated. ⌘